Chalgrove Care Home Limited

Chalgrove Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 19 and 20 October 2016 and the first day was unannounced.

Chalgrove Care and Nursing Home is a nursing and residential home registered for up to 60 predominantly older people, who may be living with dementia. The service is divided into two wings, each with their own lounges, dining rooms and bathing facilities. Edwardian wing is predominantly for people who require nursing care, and Tudor mostly accommodates people who need residential care without nursing. Until a very recent reorganisation, both wings had mixed nursing and residential care. At the time of our inspection, there were 48 people accommodated.

The service was required as a condition of its registration to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home manager was in the process of applying to register as manager. They had transferred to Chalgrove Care and Nursing Home in August 2016 from another home they were managing within the Agincare group. They had worked as the deputy matron at Chalgrove Care and Nursing Home between October 2015 and March 2016. Their predecessor has applied to cancel their registration.

The service is registered for the regulated activity of 'diagnostic and screening procedures. We have advised the provider that this is not required and have asked them to apply to remove this regulated activity from the registration.

There was a homely feel to communal areas and we observed people enjoying the company of staff who were supporting them. Staff treated people in a caring and respectful way. They spoke about people as individuals and knew about their personal preferences. Information about people's life histories was gathered to help staff get to know them. This was stored in people's care records but not in their rooms, where it would be most easily accessible to people, their relatives and staff. We have recommended the service reviews how it makes these readily and easily available for people and care staff.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns.

During the inspection there were sufficient staff available to provide people's care. However, during and after the inspection we received mixed feedback about staffing from people, their visitors and staff. Some of this suggested staff were sometimes so busy that care was hurried or delayed. Staffing levels had been reviewed shortly before the inspection. We have recommended the provider continues to keep staffing levels under review to ensure there are always sufficient, suitably skilled staff on duty.

People and their relatives spoke positively about the abilities of the staff. For example, a person living at the

service told us, "The nurses are excellent and very professional". Safe recruitment practices were followed before new staff were employed to work with people. Staff were supported through regular training and supervision to perform their roles. Nurses were able to access the required professional development to maintain their professional registration.

The staff we spoke with were motivated and enthusiastic about their roles. They had confidence the home manager would listen to their concerns, which would be received openly and dealt with appropriately.

People and their visitors spoke positively about their experiences of care at the service. However, our findings were not all consistent with this. Some people had needs that were not addressed by care plans. Care plans were regularly reviewed but did not all reflect people's current needs and some care plans contained insufficient detail about how people's needs were to be met. Whilst people often received care as specified by their care plan, this was not always accurately recorded so that staff could see when particular aspects of care were next required. You can see what action we told the provider to take at the back of the full version of the report.

An activities worker had recently started in post, following the departure of the previous activities worker not long before. We observed people in communal areas doing jigsaws and involved in group activities such as quizzes. However, a number of people were cared for in bed or preferred to stay in their rooms. On one day, we saw that a person awake in bed had no stimulation such as music, radio, television or tactile objects; this was a person who was said to enjoy classical music and the following day this was provided. Prior to the inspection we had received feedback about a lack of activity and stimulation for people. Following the inspection, the management team informed us there had always been a daily activity schedule including visiting entertainers and daily activities with other members of the care team.

People's prescribed oral medicines, injections and skin patches were managed safely. However, there were shortfalls in the recording of prescribed creams that meant we could not be sure these were always administered as prescribed. One person had dry skin on their legs and a large remaining volume of emollient cream supplied in June 2016, which was inconsistent with the cream being applied twice a day and as needed since then. You can see what action we told the provider to take at the back of the full version of the report.

People's health care needs were monitored and any changes in their health or well-being prompted a timely referral to their GP or other health care professionals.

People's consent was obtained for their care and treatment. Where there were concerns about their ability to give valid consent in relation to particular aspects of their care, the service followed the requirements of the Mental Capacity Act 2015. However, where people had appointed a lasting power of attorney, their records were not always clear about the nature of this. We have recommended the service ensures there is clarity in people's records regarding the type of power of attorney held, whether this has been registered and whether it has any specific restrictions.

People told us they were satisfied with the food and had choices about what they had to eat. People received the support they needed to eat and drink and where people had particular needs around how much to drink, their fluid intake was monitored appropriately. Up to date records were kept of people's dietary needs and preferences.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. The building was maintained, refurbishment having been undertaken since our last inspection. There were

regular checks and inspections to ensure the premises and equipment remained safe. People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm.

There was a programme of regular checks and audits by the home manager and staff, and by operations manager who oversees the home. Accidents and incidents were recorded and monitored to look for developing trends that indicated improvements were needed, as were complaints and safeguarding concerns. The nurses and management team responded positively to any shortcomings we identified during the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safe practice was not consistently followed in relation to recording and administering prescribed skin creams.

During the inspection there were sufficient staff but we did receive feedback from people and staff that low staffing levels sometimes meant that people had to wait for care.

Risks to people's safety were assessed and they were protected against hazards such as slips, trips and falls.

Is the service effective?

Good

The service was effective.

People were supported by staff who were themselves supported, through training and supervision, to perform their roles.

People were asked for their consent to their care, where they were able to give this. Staff worked within the requirements of the Mental Capacity Act 2005.

The service supported people with their health needs and referred appropriately to health care professionals when their needs changed.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

People received from staff who knew them as people and had an understanding of their personal history and individual preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans had insufficient detail or did not always accurately reflect people's needs.

Records were not always an accurate reflection of care given.

Is the service well-led?

Good

The service was well led.

People and staff had confidence the home manager would listen to their concerns and would be received openly and dealt with appropriately.

Staff were well motivated and expressed confidence in the management of the service.

Quality assurance systems were in operation to identify and drive improvements that were needed.

Chalgrove Care and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 19 and 20 October 2016 and the first day was unannounced. It was undertaken by two inspectors on both days and, on the first day, a specialist nurse advisor with expertise in nursing older people and managing care homes.

Before the inspection we reviewed the information we held about the service. This included notifications from the service about significant incidents and information from the local authority safeguarding team. We had also received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people who lived at the service, two visitors and two visiting health and social care professionals. Because people were not all able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk to us. We also spoke with the home manager, the operations manager, the provider's quality lead, two nurses, three other care staff and two ancillary staff. We reviewed seven people's care records, four people's medicines administration records, two staff files, staff supervision and training records and other records relating to how the service was managed. Following the inspection we had contact with a further person who regularly visited someone at the service.

Requires Improvement

Is the service safe?

Our findings

Peoples' oral and injected medicines, and medicines in the form of skin patches, were managed and administered safely. There were satisfactory arrangements for storage. One of the rooms where medicines were stored was very warm and air conditioning had been provided, although the room remained warm. The management team were aware and were seeking a solution to this problem. We checked a sample of medicines and found the amounts in stock tallied with the quantities recorded. Medicines administration records (MAR) contained the required information and accounted for each occasion when a prescribed medicine was due, staff having initialled the MAR when they administered the medicine or recorded why the medicine been omitted.

However, there were shortfalls in the recording of prescribed creams that meant we could not be sure these were always administered as prescribed. One person had Dermol lotion prescribed twice a day. There were no instructions in their medicines or care records regarding how this should be applied. It was signed for on only 11 days in September 2016, and on only 1, 2 and 4 October 2016, the records then stating it was 'not available'. There was no Dermol in the person's bedroom. They had Hydromol cream prescribed twice daily, but their records did not specify which areas it should be applied to. Medihoney was prescribed twice a day, but again there were no instructions for this; the tube of Medihoney in their room was dated 13 June 2016 and was empty. We drew this to the attention of one of the nurses, who told us they would follow this up. Another person had Dermol prescribed, but the MAR for this medicine had no body map or instructions explaining how and to which areas the lotion should be applied. A further person had dry skin on their legs that was in need of emollients that had been prescribed. A high volume remained of emollient cream the pharmacy had supplied in June 2016, which was inconsistent with the cream being applied twice a day and as needed since then.

These shortfalls in relation to prescribed creams were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection, thickening powder for drinks, prescribed for people who had difficulty swallowing, was stored in people's rooms. A Patient Safety Alert from NHS England in 2015 highlighted that such thickening products should be stored securely to remove the risk of accidental ingestion. We raised this with one of the nurses and with the management team, who immediately acted to address it.

During the inspection there were sufficient staff available to provide people's care. Care needs were attended to promptly, call bells were answered and care that we observed in communal areas was not rushed. People, their visitors and staff expressed mixed views about staffing. A relative said there were regular staff and that the service did not use agency staff. However, a person commented, "Staff are in and out too fast because they are so busy". Another person said, "Carers always tell me we're short of staff". A further person told us that on occasion they had waited for up to an hour for staff to answer their call bell. Two visitors commented that there did not always seem to be enough staff. The management team advised us they kept staffing levels under constant review to ensure there were sufficient, suitable skilled staff on duty. They also confirmed the time staff took to answer call bells was monitored and provided evidence of

calls being answered within five minutes and emergency calls within 60 seconds. Following the inspection they informed us their review of call bells over the past 12 months had not shown anyone waiting for an hour for any form of response. Staffing levels were based on the provider's dependency calculations, which had most recently been reviewed the week before. During the day, there were generally two nurses and five or six care workers on duty in Edwardian, and five care staff in Tudor. In addition, there was an activity coordinator who worked from 10am to 4pm five days a week as well as a social carer. At night, there were two nurses and four or five care staff across the whole service. Staff confirmed that staffing levels were generally sufficient to do what was needed but they sometimes struggled when colleagues were absent from work.

We recommend the provider continues to keep staffing levels under review to ensure there are always sufficient, suitably skilled staff on duty.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Checks had been made with the Disclosure and Barring Service (criminal records).

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Some people were independently mobile. The management team advised that people assessed as independently mobile were accommodated on the ground floor so they were less likely to use the stairs. Other risk assessments addressed areas such as malnutrition, the development of pressure sores, the use of bed rails and falls. These had mostly been reviewed within the past month. One person whose legs were vulnerable to sores was in bed with their foot pressed against the bed rail. The bed rail had protective bumpers but these did not cover the whole length of the bed rail. We drew this to the attention of the nursing team and the bumper was replaced with a more suitable one.

People were protected against hazards such as falls, slips and trips. The building was well maintained, refurbishment having been undertaken since our last inspection. The fire system had been inspected and tested on regular basis, including by a specialist contractor. The water system had tested satisfactorily in March 2016 for the absence of legionella, which are bacteria that can cause serious illness. Lifting equipment such as hoists and bath seats were inspected six monthly and certified by a specialist contractor. There were routine maintenance checks such as monthly call bell checks, window restrictor checks and checks of extractor fans.

People were kept safe from the risk of emergencies in the home. There was a business continuity plan in place that set out the actions to be taken in event of emergencies such as fire or the failure of utilities.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Accidents and incidents were recorded and monitored to look for developing trends. Each month, the home manager analysed accidents and incidents by factors such as: the type of accident or incident, the time of day, the location within the premises, whether the same people and staff or equipment were involved, and whether there were witnesses.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. The management team acted promptly to make a safeguarding referral when someone disclosed concerns to a member of the inspection team.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. For example, a relative said their family member had moved from another care home and was much happier at Chalgrove. Other people's comments included: "The nurses are excellent and very professional", "I'm happy here" and "I don't think I could have found a better place".

People were supported by staff who were supported through training and supervision to perform their roles. Staff told us they felt well supported and had regular supervision. Registered nurses had three-monthly peer supervision with the provider's quality lead. Staff confirmed they had the training they needed. There were annual or two-yearly updates in key topics such as moving and handling, safeguarding, medication (for staff who handled medicines), infection control, fire safety and food safety. There was also more specialised training available where this was identified as a training need. For example, a nurse detailed the training they had undertaken within the last year, which included refresher training for venepuncture, catheterisation, end of life care, cardiac failure and tracheostomy care. Nurses spoke openly and with confidence about revalidation, which is a requirement of their registration with the Nursing and Midwifery Council.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Where they were able to give consent people had signed their own consent forms for treatment. The home manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. However, where people had appointed a lasting power of attorney, their records did not always make clear whether this was for health and welfare or personal finance and whether the power of attorney had been registered.

We recommend the service ensures there is clarity in people's records regarding the type of power of attorney held, whether this has been registered and whether it has any specific restrictions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body and had a system for identifying when they needed to apply for authorisations to be renewed.

People told us they were satisfied with the food and were able to make choices about what they had to eat. Comments included: "The food here is very good" and "Wonderful food but he can't make chips!" Meals looked appetising and the portions were plentiful. During lunch in Tudor wing on the first day, people did not have salt and pepper on the table so they could season their meals if they wished. Someone told us they had to ask for salt and pepper. However, on the second day, cruet sets were placed on tables. Staff were also more proactive about telling people what was for lunch. The kitchen staff kept a record of people's dietary needs, likes and dislikes and told us that care staff kept them informed of any changes.

Where necessary, people were supported to eat their meals by organised and attentive staff. Staff who assisted someone to eat worked at the person's pace, checking they liked the food and chatting with them about it. Staff were observant for others who needed assistance or had finished their meals. Where people were able to drink independently they had drinks to hand. Some people's fluid intake was monitored due to particular needs; their fluid charts contained target amounts and were reviewed and totalled overnight, with recommendations for their fluid intake the following day.

People's health care needs were monitored and any changes in their health or well-being prompted a timely referral to their GP or other health care professionals. Where there were delays in obtaining an appointment staff had pursued this. A person told us how the staff were working with their GP to make sure their medicines suited them. People's care records showed that people had seen their GP when there were concerns about their health. A healthcare professional who had regular contact with the service said they were confident in the nurses and that the service was proactive in managing people's health, calling them when necessary.

Good

Is the service caring?

Our findings

People told us that staff treated them with respect and that the service had a homely feel. Someone described one of the care staff as "lovely" and said she had given her a hug and reassurance when she was anxious. Another person told us, "Staff treat me well". People who could not tell us appeared happy and contented. Over lunch on both Edwardian and Tudor wings, staff were seated at dining tables with people and people were chatting and laughing together.

People were treated with kindness and compassion in their day-to-day care and all the interactions we saw respected people's dignity. The care we observed was not rushed, and personal care took place discreetly behind closed doors. People evidently appreciated the manner in which staff supported them. For example, a person who was being assisted to eat their meal leant towards the staff member and smiled at them. Another member of staff asked someone discreetly if they could wipe something from their face and the person commented of the staff member "She's a lovely mother".

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Pain assessment scales were in active use for people who could not verbalise if they had any pain, although they did not identify outcome and effectiveness of action taken by the nurse if pain had been identified.

People received care and support from staff who had got to know them. Many of the staff had worked at the home for several years. With the reorganisation of the Tudor and Edwardian wings and the introduction of care managers and key workers instead of nurses on Tudor wing, the management team was looking at ways of strengthening the key worker role, including key workers getting to know people better and having a clearer idea of people's personal preferences.

Staff spoke about people as individuals and were able to tell us about their interests and preferences and the way they communicated. People's records included information about their personal circumstances and how they wished to be supported. 'This is Me' documents were used to detail people's life stories. We reviewed one such document that had been written by a person themselves, and another 'My life story' summary that detailed the person's family, childhood, working life, significant places and life events and activities they enjoyed. A further person's life story document detailed clearly where the person had chosen not to wish to discuss certain parts of their history. The life story documents that we saw were in people's care files rather than in the notes in their rooms, where staff would be able to access them easily and where people and their relatives would be able to add to them if they so choose.

We recommend the service reviews how it makes people's life story documents most readily and easily available for people and their care staff.

Requires Improvement

Is the service responsive?

Our findings

People and their visitors spoke positively about their experiences of care at the service. However, our findings were not all consistent with this.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care plans covered areas including maintaining a safe environment, medication, communication, physical health conditions, mental health, continence, mobility, skin integrity, nutrition and hydration and night time care.

Some people had needs that were not addressed by care plans. For example, one person was prescribed an anticoagulant medicine. Clear management guidance was not readily available for staff on what to look for, nor was this referenced within the person's care plans. Another person had sustained a skin flap, red marks and sore breasts from May to August 2016. There was no care plan in place for how to manage these. The nurses told us a further person was having Medihoney applied to protect their sore sacrum. There was no reference to this in their care plans. They also had sore groins that had resolved with medication; their care plan did not include any strategies for how this could be managed in the future if it happened again. They were observed to have developed grade one pressure damage to their right heel; there was a pillow in place but this was not in a position to offload the person's heel from their bed. The person's care records contained no reference to the grade one pressure damage and how this was being managed. We fed this back to the nurse concerned.

Care plans were regularly reviewed. However, they did not all reflect people's current needs. For example, a person had recently had their catheter removed, yet they had a catheter care plan and their night time care plan also referred to the catheter. The current medicines administration record for a person with diabetes stated they were prescribed Lantus (a type of insulin) at night only. The person's care records stated the person had insulin three times a day as well as Lantus at night.

Some care plans contained insufficient detail about how people's needs were to be met. A person with a diagnosis of diabetes had a care plan that referred to the person having a 'normal diabetic diet' with no further information about what this meant. Their diabetes care plan did not detail signs and symptoms of high and low blood sugar. Without this, there was a risk that care staff might not be able to identify signs of concern and take the appropriate action. However, the staff we spoke with were able to tell us about signs and symptoms of high and low blood sugar and what they would do if they observed these. The home manager told us they were aware this person's care plans needed development. Following the inspection, the management team confirmed that staff, including those working in the kitchen, were fully aware of how to meet an individual's dietary needs. A person's epilepsy care plan instructed staff to 'monitor for seizures' but did not detail what kind of seizures the person had or their particular signs and symptoms. Staff were able to tell us the procedure they would follow if the person had a seizure, including when to administer rescue medicine and keep seizure records.

These shortfalls in relation to care planning were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people often received care as specified by their care plan, this was not always accurately recorded so that staff could see when particular aspects of care were next required. A person had a dressing on their foot but there were no records such as a wound management plan to advise when this was due to be changed and reassessed. The nurse was unable to ascertain the last time it had been changed and the only record found indicated that the podiatrist had dressed this wound on 21 September 2016, with guidance to review in seven days. The wound matrix used in the home to track dressing changes had September dates only, with none available for October 2016. Whilst the nurse was unable to ascertain the last time it had been changed they were able to inform us about the individual's needs regarding their skin and the dressing appeared recent and the wound was healing. The person's care records stated they needed to be assisted to reposition every three to four hours to reduce the risk of pressure sores. However, the support they received was not recorded consistently; on 18 October the person was recorded as being on their back for 9 hours between 1am and 10am, with no record they had declined care. Following the inspection the management team stated repositioning charts were completed comprehensively, in the main, and that every person's mobility and tissue viability risk were assessed, with a plan in place to manage skin.

The shortfalls in relation to record keeping were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whenever we highlighted shortfalls during the inspection, the management team and nurses responded promptly to address these.

Prior to inspection we had received feedback about a lack of activity and stimulation for people. A visiting professional said they had not seen a lot of activity and things to stimulate people during previous visits. However, an activities worker had recently started in post and was having a positive impact on the provision of activity. The management team informed us this post had been vacant for only a short while, the previous activities organiser having left. They said there had always been a daily activity schedule including visiting entertainers and daily activities with other members of the care team. We observed people in communal areas doing jigsaws and involved in group activities such as quizzes. A person who had recently moved in told us they were happier now they had some entertainment.

A number of people were cared for in bed or preferred to stay in their rooms. One person who was awake in bed on the first day of the inspection had no means of stimulation, such as music, television or radio. Their care plan stated they seemed to enjoy listening to classical music and instructed staff to ensure the radio was on, but the radio was not on when we went to their room at different times. On the second day, we saw them in bed with classical music playing.

There had been four complaints logged in 2016. These had been investigated thoroughly and responded to in good time. Information about how to make a complaint was displayed in public areas so that people and their visitors could refer to it. A person told us, "I know how to complain but have not had to".

Good

Is the service well-led?

Our findings

The home manager had been in post since August, having returned to the service after previously working there in a deputy capacity. She said she was well supported by the operations manager and the provider's quality lead.

People and staff had confidence the home manager would listen to their concerns, which would be received openly and dealt with appropriately. A person told us they knew the manager by name and said she was caring and visited often to check they were okay. Staff understood and were confident about using the whistleblowing procedure. A member of staff described the home manager, "Really supportive and helps a lot. If we have any concerns we can go to her".

People and their relatives had opportunities to feed back their views about the home and quality of the service they received. People had been involved in the interview process for new staff. The annual quality assurance survey for 2016 had recently been undertaken; the results were still being analysed. The home manager had already identified that families wished to be more involved in care planning and was introducing a system for routinely inviting them to care plan reviews. The previous manager had held quarterly family meetings and had invited relatives in to meet the current manager when they handed over.

The staff we spoke with were motivated and enthusiastic about their roles. One who had worked at the service for several years told us, "I do like my job". A member of staff talked positively about the way their work had changed. The service had recently been reconfigured so the Edwardian wing accommodated predominantly people who needed nursing care and residential non-nursing care was concentrated in Tudor wing. The management team recognised that this had implications for skill mix and training, as some tasks in Tudor, such as medication and care planning, that had previously been undertaken by nurses were now undertaken by other staff. The home manager spent some of her time providing direct care, in order to oversee medicines. There had been consultation with staff regarding the changes and the home manager told us she was proud of the way staff had embraced these.

The home manager had notified CQC about significant events, as required by the regulations. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. There was a programme of regular checks and audits; action plans were developed to address any shortcomings identified. Monthly audits by the home's manager and staff covered areas including staff files, care files medicines, slings. The operations manager undertook quarterly audits as part of their oversight of service. The provider's quality lead reported on the quarterly audits every six months, along with accidents and incidents, safeguarding and complaints, to the quality management committee.

The organisation that owns the service was working in partnership with key organisations to support care provision and service development. They were in the process of launching a care academy at a local college to encourage people to start working in social care and nursing. A senior manager also had the role of

Admiral nurse for the organisation, Admiral Nurses are registered nurses who specialise in dementia, who support families of people living with dementia.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care and treatment was not always satisfactorily planned to address people's needs. Some care plans were insufficiently detailed or did not reflect current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way because topical medicines were not managed safely. There were insufficient instructions for staff in relation to people's prescribed creams and people did not always have their skin creams administered as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Accurate, complete and contemporaneous of care given were not always maintained.